		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003038

Facility Name: ELMHURST EXTENDED CARE CENTER

Address: 200 E. LAKE STREET (Number) ELMHURST (City) 60126 (Zip Code)

County: DUPAGE

Telephone Number: 630-834-4337 **Fax #** 630-834-4122

IDPA ID Number: 0003038

Date of Initial License for Current Owners: 02/18/1961

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: THEODORE F. SLUPIK **Telephone Number:** 630-357-0096

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/02 to 07/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JOHN MASSARD
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) THEODORE F. SLUPIK, CPA, PRESIDENT
(Firm Name & Address) SLUPIK & ASSOCIATES, LTD. 1700 PARK STREET SUITE 202, NAPERVILLE, IL 60563
(Telephone) 630-357-0096 Fax # 630-357-0592

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,726	3,764	6,393	11,883	8
9	SNF/PED					9
10	ICF	2,556	13,877		16,433	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,282	17,641	6,393	28,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.27%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/09/1960

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 6,393

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 07/31/03 Fiscal Year: 07/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	206,846	18,233	6,434	231,513		231,513		231,513			1
2	Food Purchase		131,929		131,929		131,929		131,929			2
3	Housekeeping	165,821	29,062	1,127	196,010		196,010		196,010			3
4	Laundry	25,586	6,655	530	32,771		32,771		32,771			4
5	Heat and Other Utilities			100,909	100,909		100,909	(415)	100,494			5
6	Maintenance	38,842		94,447	133,289		133,289		133,289			6
7	Other (specify):*											7
8	**TOTAL General Services**	437,095	185,879	203,447	826,421		826,421	(415)	826,006			8
	B. Health Care and Programs											
9	Medical Director			31,900	31,900		31,900		31,900			9
10	Nursing and Medical Records	1,762,433	130,937	82,787	1,976,157	(87,351)	1,888,806		1,888,806			10
10a	Therapy	44,774		79,000	123,774	87,351	211,125		211,125			10a
11	Activities	63,387	805	1,572	65,764		65,764		65,764			11
12	Social Services	34,552		375	34,927		34,927		34,927			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,905,146	131,742	195,634	2,232,522		2,232,522		2,232,522			16
	C. General Administration											
17	Administrative	152,395		(1,883)	150,512		150,512	1,883	152,395			17
18	Directors Fees			47,129	47,129		47,129		47,129			18
19	Professional Services			51,994	51,994		51,994	(5,848)	46,146			19
20	Dues, Fees, Subscriptions & Promotions			66,360	66,360		66,360	(19,916)	46,444			20
21	Clerical & General Office Expenses	186,544	8,419	66,102	261,065		261,065	(9,968)	251,097			21
22	Employee Benefits & Payroll Taxes			356,496	356,496		356,496		356,496			22
23	Inservice Training & Education			16,120	16,120		16,120		16,120			23
24	Travel and Seminar			3,395	3,395		3,395	(2,917)	478			24
25	Other Admin. Staff Transportation			4,394	4,394		4,394		4,394			25
26	Insurance-Prop.Liab.Malpractice			85,205	85,205		85,205		85,205			26
27	Other (specify):*											27
28	**TOTAL General Administration**	338,939	8,419	695,312	1,042,670		1,042,670	(36,766)	1,005,904			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,681,180	326,040	1,094,393	4,101,613		4,101,613	(37,181)	4,064,432			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER #0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			159,651	159,651		159,651	(57,992)	101,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			533	533		533	(533)				32
33	Real Estate Taxes			39,117	39,117		39,117	(181)	38,936			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			199,301	199,301		199,301	(58,706)	140,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			220,366	220,366		220,366		220,366			39
40	Barber and Beauty Shops			11,155	11,155		11,155		11,155			40
41	Coffee and Gift Shops			11,398	11,398		11,398		11,398			41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* **BAD DEBTS**			(11,156)	(11,156)		(11,156)	11,156				43
44	**TOTAL Special Cost Centers**			293,083	293,083		293,083	11,156	304,239			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,681,180	326,040	1,586,777	4,593,997		4,593,997	(84,731)	4,509,266			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(875)	VAR		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(57,713)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,968)	21		13
14	Non-Care Related Interest	(533)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,917)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	1,883	17		21
22	Special Legal Fees & Legal Retainers	(5,848)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	11,156	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(19,916)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,731)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,731)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
ELMHURST EXTENDED CARE CENTER

ID# 0003038
Report Period Beginning: 08/01/02
Ending: 07/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BARBER / BEAUTY SHOP EXPENSE	$ (415)	5	1
2	S/L DEPRECIATION	(279)	30	2
3	REAL ESTATE TAX	(181)	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(875)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(415)	0	0	0	0	0	0	0	0	0	0	(415)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(415)	0	0	0	0	0	0	0	0	0	0	(415)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	1,883	0	0	0	0	0	0	0	0	0	0	1,883	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,848)	0	0	0	0	0	0	0	0	0	0	(5,848)	19
20	Fees, Subscriptions & Promotions	(19,916)	0	0	0	0	0	0	0	0	0	0	(19,916)	20
21	Clerical & General Office Expenses	(9,968)	0	0	0	0	0	0	0	0	0	0	(9,968)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,917)	0	0	0	0	0	0	0	0	0	0	(2,917)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,766)	0	0	0	0	0	0	0	0	0	0	(36,766)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,181)	0	0	0	0	0	0	0	0	0	0	(37,181)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 **Report Period Beginning:** 08/01/02 **Ending:** 07/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(57,992)	0	0	0	0	0	0	0	0	0	0	(57,992)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(533)	0	0	0	0	0	0	0	0	0	0	(533)	32
33	Real Estate Taxes	(181)	0	0	0	0	0	0	0	0	0	0	(181)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(58,706)	0	0	0	0	0	0	0	0	0	0	(58,706)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):* **BAD DEBTS**	11,156	0	0	0	0	0	0	0	0	0	0	11,156	43
44	**TOTAL Special Cost Centers**	11,156	0	0	0	0	0	0	0	0	0	0	11,156	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(84,731)	0	0	0	0	0	0	0	0	0	0	(84,731)	45

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NOT APPLICABLE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		NOT APPLICABLE	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BONNIE GIBBONS	BOARD MEMBER		75.90		8	20.00		$ 39,811	18.3	1
2	PEGGY MASSARD	BOARD MEMBER				40	100.00		40,546	21.1	2
3	JOHN MASSARD	ADMINISTRATOR		24.10		50	100.00		152,395	17.1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 232,752		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	INTEREST EXPENSE										533	10
11	INTEREST INCOME										(533)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	39,654	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	36,721	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,933)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	42,050	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	39,117	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	34,251	8
	1999	34,357	9
	2000	34,376	10
	2001	35,645	11
	2002	37,798	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ELMHURST EXTENDED CARE CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0003038

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-36-309-029	NURSING HOME	$ 37,798.00	$ 37,798.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,798.00	$ 37,798.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior 2 STORY BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE	41,851	1961	$ 92,016	1
2	PARKING LOT			6,950	2
3	TOTALS	41,851		$ 98,966	3

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	39		1961	1961	$ 122,779	$	40	$	$	$ 122,779	4
5	73		1976	1976	1,174,345	18,386	40	18,107	(279)	927,923	5
6			1980	1980	46,390	1,057	40	1,057		28,000	6
7			1998	1998	700	73	10	70	(3)	350	7
8			1998	1998	43,075	2,872	15	2,872		12,922	8
	Improvement Type**										
9	OTHER			1983	7,336		12			7,336	9
10	OTHER			1984	5,800		15			5,800	10
11	OTHER			1987	1,630		10			1,630	11
12	OTHER			1989	7,744		10			7,744	12
13	FRONT WALK			1995	4,900	321	10	490	169	4,001	13
14	CEILING TILE			1996	4,960	325	20	248	(77)	1,792	14
15	NEW SIGN			1997	11,049		10	1,105	1,105	7,120	15
16	RETAINING WALL			1998	6,800	607	10	680	73	3,445	16
17	FIRE DAMPERS			1999	6,169	551	10	617	66	2,776	17
18	REWIRING			1999	4,356	389	10	435	46	1,960	18
19	TILE			1999	2,945	271	20	147	(124)	663	19
20	WOOD FENCE			2000	1,349	168	10	135	(33)	472	20
21	PARKING LOT			2000	1,000	125	10	100	(25)	350	21
22	HAND RAIL			2001	1,813	317	10	181	(136)	453	22
23	RAIL			2001	2,527	442	10	253	(189)	632	23
24	KITCHEN AIR UNIT			2002	17,790		20	867	867	1,312	24
25	GATES & RAILINGS			2002	2,500	165	20	122	(43)	184	25
26	LAUNDRY EXHAUST DUCTWORK			2003	1,980	792	10	99	(693)	99	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,479,937	$ 26,861		$ 27,585	$ 724	$ 1,139,743	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 910,052	$ 46,267	$ 66,289	$ 20,022	10	$ 565,660	71
72	Current Year Purchases	152,797	84,184	7,785	(76,399)	10	7,785	72
73	Fully Depreciated Assets	72,330					72,330	73
74								74
75	TOTALS	$ 1,135,179	$ 130,451	$ 74,074	$ (56,377)		$ 645,775	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT	MINI BUS	1995	$ 44,094	$ 2,339	$	$ (2,339)	3	$ 44,094	76
77										77
78										78
79										79
80	TOTALS			$ 44,094	$ 2,339	$	$ (2,339)		$ 44,094	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,758,176	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 159,651	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,659	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (57,992)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,829,612	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2003 DODGE RAM	$ 44,099	$ 19,403	$ 19,403	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 44,099	$ 19,403	$ 19,403	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	NOT APPLICABLE			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39.3	11,018	# of prescrpts			220,366		11,018	220,366	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$ 220,366	$	11,018	$ 220,366	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 07/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 712,916	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	136,582		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,341		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE F/MEDC / DEF TAX	200,648		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,160,487	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,966		13
14	Buildings, at Historical Cost	1,557,915		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,072,303		16
17	Accumulated Depreciation (book methods)	(2,190,992)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CSV - OFFICERS LIFE/DEP.	109,731		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 647,923	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,808,410	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 190,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,773		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,077		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,050		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	35,998		35
	Other Current Liabilities(specify):			
36	ACCRUED 401(K) / ACCRUED INS	14,883		36
37	DIVIDENDS PAYABLE	300,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 856,687	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 856,687	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 951,723	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,808,410	$	48

***(See instructions.)**

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 899,185	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 899,185	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	352,538	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 52,538	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 951,723	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,351,806	1
2	Discounts and Allowances for all Levels	(1,064,390)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,287,416	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	570,974	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 570,974	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	14,494	12
13	Barber and Beauty Care	17,625	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	257,000	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 289,119	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,803	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,803	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,173,312	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	826,421	31
32	Health Care	2,232,521	32
33	General Administration	1,042,670	33
	B. Capital Expense		
34	Ownership	199,301	34
	C. Ancillary Expense		
35	Special Cost Centers	293,084	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,593,997	40
41	**Income before Income Taxes (line 30 minus line 40)****	579,315	41
42	**Income Taxes**	(226,777)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 352,538	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,120	$ 83,460	$ 39.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,323	13,323	336,935	25.29	3
4	Licensed Practical Nurses	17,936	17,936	379,337	21.15	4
5	Nurse Aides & Orderlies	61,441	61,441	725,710	11.81	5
6	Nurse Aide Trainees	5,793	5,793	49,285	8.51	6
7	Licensed Therapist	2,168	2,168	87,351	40.29	7
8	Rehab/Therapy Aides	2,281	2,281	35,688	15.65	8
9	Activity Director	2,080	2,080	30,156	14.50	9
10	Activity Assistants	3,661	3,661	33,231	9.08	10
11	Social Service Workers	2,120	2,120	34,552	16.30	11
12	Dietician	2,088	2,088	42,411	20.31	12
13	Food Service Supervisor					13
14	Head Cook	2,237	2,237	33,660	15.05	14
15	Cook Helpers/Assistants	10,118	10,118	104,090	10.29	15
16	Dishwashers	3,600	3,600	27,278	7.58	16
17	Maintenance Workers	2,125	2,125	39,671	18.67	17
18	Housekeepers	12,000	12,000	115,173	9.60	18
19	Laundry	3,065	3,065	23,775	7.76	19
20	Administrator	2,120	2,120	152,396	71.88	20
21	Assistant Administrator	2,040	2,040	60,509	29.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,560	6,560	123,969	18.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,120	2,120	53,507	25.24	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,979	1,979	26,392	13.34	31
32	Other Health Care(specify)					32
33	Other(specify) OT / RESTORAT	2,975	2,975	82,644	27.78	33
34	TOTAL (lines 1 - 33)	165,950	165,950	$ 2,681,180 *	$ 16.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	159	31,900	9.3	36
37	Medical Records Consultant	61	1,350	10.1	37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	2,520	10.1	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	499	10.1	44
45	Social Service Consultant	4	375	12.3	45
46	Other(specify) DENTIST	24	600	10.1	46
47	BOARD OF DIRECTORS	1,200	39,811	18.3	47
48					48
49	TOTAL (lines 35 - 48)	1,462	$ 77,055		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	177	$ 8,496	10.1	50
51	Licensed Practical Nurses	426	16,735	10.1	51
52	Nurse Aides		12,876	10.1	52
53	TOTAL (lines 50 - 52)	603	$ 38,107		53

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN MASSARD	ADMINISTRATOR	24.10	$ 152,395
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 152,395

B. Administrative - Other

Description	Amount
A & G OFFICERS LIFE	$ (1,883)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ (1,883)

C. Professional Services

Vendor/Payee	Type	Amount
SLUPIK AND ASSOCIATES	ACCOUNTING	$ 15,125
SIGEL & ALBIN	LEGAL RETAINER	2,220
SIGEL & ALBIN	LEGAL FEES	3,628
R.E HARRINGTON	UNEMPLOYMENT	300
BENEFIT PLANNING CONSULT	PLAN ADMINISTRATION	2,186
OTHER	MISCELLANEOUS	5,745
VARIOUS	COMPUTER EXPENSE	22,790
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 51,994

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,616
Unemployment Compensation Insurance	21,627
FICA Taxes	202,501
Employee Health Insurance	71,817
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYER 401(K) MATCH	14,233
EMPLOYEE RELATIONS	3,702
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,496

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,177
Health Care Worker Background Check	538
(Indicate # of checks performed 45)	
YELLOW PAGE ADVERTISING	19,916
EMPLOYMENT AGENCY FEE	9,000
LICENSES	1,206
PUBLIC RELATIONS	11,315
ILLINOIS HEALTH CARE DUES	5,746
OTHER	6,462
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(19,916)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,444

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,917
In-State Travel	478
Seminar Expense	
LESS ADJUSTMENTS	(2,917)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 478

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER # 0003038 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ELMHURST EXTENDED CARE CENTER **#** 0003038 **Report Period Beginning:** 08/01/02 **Ending:** 07/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOCIATION**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **34,777** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **UNKNOW**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **NO, COMPANY IS REIMBURSED BY OFFICER**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **SLUPIK & ASSOCIATES, LTD.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.